AMENDED IN SENATE MARCH 30, 2005

SENATE BILL No. 364

Introduced by Senator Perata

February 17, 2005

An act to amend Section ~~1371.4~~ *1371.35* of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 364, as amended, Perata. Health care service plans.

~~Under existing~~

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, ~~the Department of Managed Health Care regulates~~ *provides for the regulation of* health care service plans~~. Existing~~ *by the Department of Managed Health Care and makes a violation of the act a crime. Under existing* law ~~requires~~*,* a health care service plan *is required* to reimburse *within a designated timeframe, a complete claim submitted by a provider, and this responsibility is not waived by the plan requiring its contracting entities to pay claims for covered services* ~~providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as specified~~.

~~This bill would specify that that reimbursement is to occur in accordance with related provisions specifying how health care service plans reimburse claims.~~

This bill would require a plan to assure that claims submitted by a physician who contracts with one of the plan's contracting entities, are paid in accordance with regulations adopted by the department as well as the contract. The bill would also require the plan to assure that claims submitted by a physician who does not contract with either a plan or one of its contracting entities, are paid in accordance with regulations adopted by the department.

Because the bill would specify additional requirements for a health care service plan, the violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

~~SECTION 1. Section 1371.4 of the Health and Safety Code is amended to read:~~

SECTION 1. Section 1371.35 of the Health and Safety Code is amended to read:

1371.35. (a) A health care service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the complete claim by the health care service plan. However, a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the plan pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 working days after receipt of the reasonable relevant information to request the further

information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. A plan shall specify, in a written notice sent to the provider within the respective 30- or 45-working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt of the additional information, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(f) *(1)* The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services. *For purposes of this section, those medical groups, independent practice association, and other contracting entities are designated as subcontractors.* This section shall not be construed to prevent a plan from assigning, by a written contract, the responsibility to pay interest and late charges pursuant to this section to medical groups, independent practice associations, or other entities. *The plan shall assure that the subcontractors comply with this section and regulations adopted pursuant to this section.*

(2) The plan shall assure that claims submitted by a physician who contracts with a subcontractor are paid in accordance with

regulations adopted pursuant to this section and with the contract between the physician and the subcontractor. For purposes of this section, a physician surgeon who contracts with a subcontractor is designated as a contracting physician.

(3) The plan shall assure that claims submitted by a physician who does not contract with a plan or subcontractor are paid by the plan or subcontractor in accordance with regulations adopted pursuant to this section. For purposes of this section, a physician who does not contract with a plan or subcontractor is designated as a noncontracting physician.

(4) If a physician has a contract with a plan but does not have a contract with a subcontractor, the physician may submit a claim to the plan, and the plan shall pay the claim pursuant to the terms of the contract between the plan and the physician.

(g) A plan shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the plan's actions to resolve the claim, to the provider that submitted the claim.

(h) A health care service plan shall not request or require that a provider waive its rights pursuant to this section.

(i) This section shall not apply to capitated payments.

(j) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 in the United States on or after September 1, 1999.

(k) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 1371.

(*l*) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a

crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~1371.4. (a) A health care service plan, or its contracting medical providers, shall provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.~~

~~(b) In accordance with Section 1371.35, a health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.~~

~~(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.~~

~~(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the~~

~~disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.~~

~~(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.~~

~~(f) Subdivisions (b), (e), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.~~

~~(g) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.~~

~~(h) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.~~

~~(i) The definitions set forth in Section 1317.1 shall control the construction of this section.~~

~~(j) (1) A health care service plan that meets the criteria set forth in paragraphs (3) and (4) of subdivision (a) of Section 1262.8 and that is contacted by a hospital pursuant to Section 1262.8 shall, within 30 minutes of the time the hospital makes the initial telephone call requesting information, do all of the following:~~

~~(A) Discuss the enrollee's medical record with the noncontracting physician and surgeon or an appropriate representative of the hospital.~~

~~(B) Transmit any appropriate portion of the enrollee's medical record requested by the appropriate hospital representative or the noncontracting physician and surgeon to the hospital by facsimile transmission or electronic mail, whichever method is requested by the appropriate hospital representative or the noncontracting physician and surgeon. The health care service plan shall transmit the record in a manner that complies with all legal requirements to protect the enrollee's privacy.~~

~~(C) Either authorize poststabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.~~

~~(2) A health care service plan that meets the criteria set forth in paragraphs (3) and (4) of subdivision (a) of Section 1262.8 and that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for poststabilization care rendered to the enrollee if any of the following occur:~~

~~(A) The health care service plan authorizes the hospital to provide poststabilization care.~~

~~(B) The health care service plan does not respond to the hospital's initial contact or does not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee within the timeframe set forth in paragraph (1).~~

~~(C) There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires poststabilization care.~~

~~(3) Paragraphs (1) and (2) do not apply to a physician and surgeon who provides medical services at the hospital.~~

~~(4) A health care service plan that meets the criteria set forth in paragraphs (3) and (4) of subdivision (a) of Section 1262.8 shall not require a hospital representative or a noncontracting physician and surgeon to make more than one telephone call pursuant to Section 1262.8 to the number provided in advance by the health care service plan. The representative of the hospital that makes the telephone call may be, but is not required to be, a physician and surgeon.~~

~~(5) An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care~~

~~service plan and the department. The department shall forward that report to the State Department of Health Services.~~

~~(6) For purposes of this section, "poststabilization care" means medically necessary care following stabilization of an emergency medical condition.~~

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